Within corporate limits

Dr. E. Brunig
Dr. Mallinger

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01094

1104 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Cumberland rural X
STREET ADDRESS (If rural give location) R. F. D. # 2

3. NAME OF DECEASED: (Type or Print) John (First) Thomas (Middle) Adams (Last)

4. DATE OF DEATH: (Month) 2/9 (Day) (Year) 1955

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: Feb 7, 1955
9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days 2 IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland Cumberland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John [redacted] Adams
14. MOTHER'S MAIDEN NAME: Mary Zies

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Ft. Chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

762.5
IMMEDIATE CAUSE (A) prematurity, respir. depression
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/7, 1955, to 2/9, 1955, that I last saw the deceased alive on 2/8, 1955, and that death occurred at 7 15 A M., from the causes and on the date stated above.
SIGNATURE Elizabeth Jennings ADDRESS 55 Greene St Cumberland Md. DATE SIGNED 2/9/55
M. D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 2-11-1955
NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery
LOCATION (City, town, or county) (State) Green Spring W Va

DATE REC'D BY LOCAL REGISTRAR Feb. 9 1955
REGISTRAR'S SIGNATURE Walter K. Frantz, M.D.
24. FUNERAL DIRECTOR W. H. Right
ADDRESS Cumberland Md
3025263322

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 16 1955
BUREAU V. S.

11 of

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01095

1105 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (In this place) 2/14/48
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural give location) 111 South Street 1

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) (Last) Appel

4. DATE OF DEATH (Month) (Day) (Year) February 22, 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 10/16/1877

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Laborer - Oddjobs

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): W. Va. (Berkeley County)

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Lucas Appel

14. MOTHER'S MAIDEN NAME: Sarah Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 223-16-9911-A

17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

ANTECEDENT CAUSE (B) DUE TO Cerebral Arteriosclerosis — ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Chronic Myocarditis — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary Sclerosis. — ?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 19 55, to Feb. 22, 19 55, that I last saw the deceased alive on Feb. 22, 19 55, and that death occurred at 11:05 P.M., from the causes and on the date stated above.

SIGNATURE Laurence E. McLean M.D. ADDRESS 49 Greene St. DATE SIGNED 2-23-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Feb. 25, 1955 — NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem. — LOCATION (City, town, or county) (State) Near Oldtown, Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 24, 1955 — REGISTRAR'S SIGNATURE Wintes R. Frantz, M.D. — 24. FUNERAL DIRECTOR John J. Hafer, Sr. — ADDRESS Cumbo, Md.

RECEIVED
MAR 1 1955
BUREAU V. S.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01096

1 1158

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Westernport
LENGTH OF STAY (in this place) 48 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 mi E. of Westernport

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport-Rural X
STREET ADDRESS (If rural give location) 1 Mi. E. of Westernport

3. NAME OF DECEASED: (Type or Print) (First) Robert Calvin (Middle) (Last) Arnold

4. DATE OF DEATH: (Month) Feb. (Day) 20 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: 5/4/1885

9. AGE last birthday 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor

10B. KIND OF BUSINESS OR INDUSTRY: Rail-road

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: August Arnold

14. MOTHER'S MAIDEN NAME: Anna Belle Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mrs. R.C. Arnold, Westernport, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

350X

IMMEDIATE CAUSE (A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerotic Parkinsons Disease — 8 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 1946 to Feb 20, 1955, that I last saw the deceased alive on Feb 20, 1955 and that death occurred at 1:30 P M, from the causes and on the date stated above.

SIGNATURE James H Weimer Jr M. D. ADDRESS Piedmont DATE SIGNED 2-21-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2/23/55 | NAME OF CEMETERY OR CREMATORY Philos Cem. | LOCATION (City, town, or county) Westernport, (State) Md.

DATE REC'D BY LOCAL REGISTRAR 2-23-55 | REGISTRAR'S SIGNATURE Mrs Jan C. Kelly

24. FUNERAL DIRECTOR ADDRESS E.S. Boal-Westernport, Md.

RECEIVED
FEB 24 1955
BUREAU V. S.

Within corporate limits

1106

01097
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 722 Elm St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 722 Elm St.

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) Floto (Last) Baker

4. DATE OF DEATH (Month) (Day) (Year): Feb. 1 1955

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: Aug. 4-1901

9. AGE last birthday: 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Taxicab driver

10b. KIND OF BUSINESS OR INDUSTRY: Astor Cab Co.

11. BIRTHPLACE (State or foreign country): Meyersdale, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John E. Baker

14. MOTHER'S MAIDEN NAME: Rebecca M. Floto

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes
(If Yes, give war or dates of service): 1924

16. SOCIAL SECURITY NO.: 214-05-9407

17. INFORMANT & ADDRESS: (sister) Mrs. Florence Weires, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) 181X Carcinoma of the bladder with - about 4 years

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Metastasis to lungs about 2 months.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: H.V. Deming M.D. H.V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒*
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED: Feb. 1-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 5, 1955	Union Cemetery	Meyersdale, Pennsylvania

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 2, 1955	Winter K. Frantz, M.D.	James L. Scarpelli	Cumberland, Md.

VS. A15A - 5 - 53

RECEIVED
FEB 4 1965
BUREAU V. S.

Within corporate limits: 1107

01098

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland

LENGTH OF STAY (in this place): 50 Yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 119 Pa. Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Cumberland

STREET ADDRESS (If rural, give location): 119 Pa. Ave.

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)	4. DATE OF DEATH (Month) (Day) (Year)
Humbird F. Baldwin	Feb. 16 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married	April 29-1904	50 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retire Inspector	Kelley-Springfield Tire Co	Cumberland, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Frank M. Baldwin	Doris Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	220-10-1425	(wife) Lillian H. Baldwin, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Cerebral hemorrhage (apoplexy)	sudden
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: H. V. Dening M.D. H. V. Dening M. D.

M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED: Feb. 16-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 18, 1955	Mt. Pleasant Cemetery	Near Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 17, 1955	Walter K. Frantz, M.D.	James F. Scarpelli, "	" "

RECEIVED
FEB 23 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1159

CERTIFICATE OF DEATH

Reg. Dist. No. 01099

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY: Allegany. STATE: MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: 43 Westernport,

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: CO 218 Maryland Avenue.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport. 43

STREET ADDRESS (If rural, give location): 218 Maryland Avenue. 1

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) Perry (Last) Bell.

4. DATE OF DEATH: (Month) (Day) (Year) February 18, 1955.

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married.	Oct. 1875.	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired.	W.Va.P.& P.Co.	Harpers Ferry, W.Va.	USA.

13. FATHER'S NAME: Jacob P. Bell. 217-05-1107 A.

14. MOTHER'S MAIDEN NAME: Lalley.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Edward P. Bell.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
2040 Immediate cause	(a) Hypostatic Pneumonia.	3dys
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Senility.,	
	DUE TO (c) Lymphatic Leukemia	5yrs

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis, 10yrs

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 1/7, 19 55, to Feb 18 1955., that I last saw the deceased alive on 2/18, 19 55 and that death occurred at 11/30 m., from the causes and on the date stated above.

SIGNATURE: James A Bell Jr M.D. DEGREE OR TITLE: M.D. ADDRESS: Piedmont W Va. DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial.	2-21-55.	Philos Cemetery.	Westernport, Maryland.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-21-55	Mr Jon C. Kelly	W Harold Fuller Jr	Piedmont, W.Va.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01100

CERTIFICATE OF DEATH

1108

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 10hr.-55min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Garrett
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland
STREET ADDRESS (If rural give location) 11X-2

3. NAME OF DECEASED: (Type or Print) (First) Wallace (Middle) (Last) Bowser

4. DATE OF DEATH (Month) Feb. (Day) 13 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 1/14/1877

9. AGE last birthday 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farming

10B. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Bowser

14. MOTHER'S MAIDEN NAME: Susan Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS. Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

45 1/2
IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(A) Dissecting Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 16 hr.
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/13, 1955, to 2/13, 1955, that I last saw the deceased alive on 2/13, 1955, and that death occurred at 4:25PM, from the causes and on the date stated above.

SIGNATURE James M Bowers M.D. ADDRESS Cumberland Md. DATE SIGNED 2/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Feb. 16, 1955 — NAME OF CEMETERY OR CREMATORY Oakland Cemetery — LOCATION (City, town, or county) Oakland, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR Feb. 14, 1955 — REGISTRAR'S SIGNATURE Charles R. Frantz, M.D.

24. FUNERAL DIRECTOR H. C. Leighton — ADDRESS "

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits? : 1109

01101
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 6 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va. COUNTY Hampshire; CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Romney, rural; STREET ADDRESS (If rural, give location) Star Route

3. NAME OF DECEASED: (Type or Print) (First) Ray (Middle) Everous (Last) Buckley

4. DATE OF DEATH (Month) Feb. (Day) 21 (Year) 19 55

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: April 12-1915

9. AGE Last birthday: 39 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer in Construction

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry.

11. BIRTHPLACE (State or foreign country): W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Buckley

14. MOTHER'S MAIDEN NAME: Mary E. Doan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 236-20-9687

17. INFORMANT & ADDRESS: Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
925.3 Immediate cause	(a) Cerebral anoxia	6 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Traumatic asphyxia	1 hr.
	DUE TO (c) Bronchial Pneumonia	3 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: 20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. 21b. PLACE (Home, farm, factory, street, office bldg., etc.) B&O Railroad INJURY 21c. (City or town) Cumberland (County) Allegany (State) Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Feb.15/55 2:30 P. M. 21e. INJURY OCCURRED While at work ☐ Not while at work ☒ 21f. HOW DID INJURY OCCUR? Working in an 18 ft. pit, dirt sidewall caved in on him.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V.Deming M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED Feb.21-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb.23,1955	St Lukes Cemetery	Romney, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb.22,1955	Walter L. Trautz, M.D.	Trautz Funeral Home	Romney, West Virginia

VS. A15A - 5 - 53

Within corporate limit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01102

1110 CERTIFICATE OF DEATH Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 31 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 35 South St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural, give location) 35 South St

3. NAME OF DECEASED (Type or Print): (First) Otta (Middle) May (Last) Burner

4. DATE OF DEATH: (Month) Feb (Day) 16 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec 6, 1878

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S

13. FATHER'S NAME: Hampson Smoot

14. MOTHER'S MAIDEN NAME: Ann Ryman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs Marvin Campbell-35 South St

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Mesenteric Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

ANTECEDENT CAUSE (S) DUE TO (B) Uterine Fibroids — 1 year.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-14-1955, to 2/16 1955, that I last saw the deceased alive on 2-16, 1955, and that death occurred at 8:55 PM, from the causes and on the date stated above.

SIGNATURE Hubbard Hobson M.D. ADDRESS 126 Washington St Cumberland Md DATE SIGNED 2/17/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: Feb 19, 1955

NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REGISTRAR: Feb. 17, 1955

REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: John F. Hafer Cumberland Md

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
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BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **01104**

1166 CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole
MARYLAND LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) Nancy (Middle) A. (Last) Chichetto

4. DATE OF DEATH: (Month) Feb. (Day) 15, (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 5, 1889

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR: Months 5 Days 10 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salmona, Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin DeSantis

14. MOTHER'S MAIDEN NAME: Marie Pioluccia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Louis Chichetto

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO: Myocarditis - decompensating

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO: chronic myocarditis

(c)

Interval Between Onset And Death: Jan 15 54

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1953, to Feb 15, 1955, that I last saw the deceased alive on Feb 10, 1955, and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE J. Chiffm (Degree or title) MD ADDRESS Keyser W. Va. DATE SIGNED 2-16-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2-17-55 NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery LOCATION (City, town, or county) Keyser, (State) W. Va.

DATE REC'D BY LOCAL REGISTRAR 2-17-55 REGISTRAR'S SIGNATURE Mrs Jean C. Kelly

24. FUNERAL DIRECTOR Rogers Funeral Home, ADDRESS Keyser, W. Va.

VS. A15

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01105

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Cumberland
LENGTH OF STAY (in this place) 20 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 119 Decatur St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 119 Decatur St.

3. NAME OF DECEASED: (Type or Print) (First) Benjamin (Middle) Prescott (Last) Cooke

4. DATE OF DEATH (Month) Feb. (Day) 27 (Year) 19 55

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Oct. 31-1879

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Retired, District Mgr.

10b. KIND OF BUSINESS OR INDUSTRY: Bone Al. & Brass Co.

11. BIRTHPLACE (State or foreign country): Bedford, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Cooke

14. MOTHER'S MAIDEN NAME: Mary Conn McCoslin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 192-05-6709

17. INFORMANT & ADDRESS: (wife) Laura Small Cooke, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary occlusion — Interval between onset and death: about 3/4 hours.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Coronary sclerosis — ?

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. V. Deming M. D. H. V. Deming M. D. M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED Feb. 27-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF March 2 1955 — NAME OF CEMETERY OR CREMATORY St. Peter and Paul Cem. — LOCATION (City, town, or county) Cumberland, Maryland (State)

DATE REC'D BY LOCAL REG. Feb. 28, 1955 — REGISTRAR'S SIGNATURE Vinton L. Hanly, M.D.

24. FUNERAL DIRECTOR A. Lee Silcox — ADDRESS Cumberland, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01106

1160 CERTIFICATE OF DEATH Reg. Dist. No. 9

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

1. PLACE OF DEATH. COUNTY Allegany MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg LENGTH OF STAY (In this place) 4 mo. HOSPITAL OR INSTITUTION OR STREET ADDRESS 61 Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Md. COUNTY Allegany CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg STREET ADDRESS (If rural, give location) 126 W Walnut St.

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Clement (Last) Cookerly

4. DATE OF DEATH: (Month) 2 (Day) 12 (Year) 1955

5. SEX: M 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married 8. DATE OF BIRTH: 11-20-1896 9. AGE last birthday 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator Operator 10B. KIND OF BUSINESS OR INDUSTRY: Public Bldg. 11. BIRTHPLACE (State or foreign country): Cumberland Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Cookerly 14. MOTHER'S MAIDEN NAME: Maigne May Shumate

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) 16. SOCIAL SECURITY NO. 217-14-4966 17. INFORMANT & ADDRESS: Mrs. Clement Cookerly 126 Walnut St. Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cachexia & Toxemia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks 3 d.

ANTECEDENT CAUSE (S) DUE TO (B) Metastatic Carcinoma — 8 mos

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Adenocarcinoma - cecum — 15 mos.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Buerger's Disease — 19 yrs.

19A. DATE OF OPERATION: 8/23/54 19B. MAJOR FINDINGS OF OPERATION: Neoplastic mass post. cecum, involving body wall; Generalized met. early 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/10, 1954, to 2/12, 1955, that I last saw the deceased alive on 2/12, 1955, and that death occurred at 1:50 P M, from the causes and on the date stated above.

SIGNATURE Frank T Garrat M.D. ADDRESS Frostburg DATE SIGNED 2/14/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2-15-1955 NAME OF CEMETERY OR CREMATORY Frostburg Park LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 2-15-55 REGISTRAR'S SIGNATURE Dee Nancy N. Roe 24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

Within corporate limits 1112

01107
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE W.Va. COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Mouth of Seneca 8 X-3
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Ermie (Middle) F. (Last) Cooper

4. DATE OF DEATH (Month) Feb. (Day) 14 (Year) 19 55

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: March 22-1906

9. AGE last birthday: 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): Housework at Own Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pendelton, Co., W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ben Y Cooper

14. MOTHER'S MAIDEN NAME: Annie Morral

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

17 5 X

Immediate cause (a) Pulmonary infarction — Interval Between Onset and Death: 2 weeks.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Pulmonary embolism also had — 3 or 4 days

DUE TO

(c) Carcinoma of left ovary. — ?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Died on operating table, while taking an anesthetic.

19a. DATE OF OPERATION: Feb.14 -1955

19b. MAJOR FINDING OF OPERATION: Carcinoma of left ovary.

20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H. V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Feb.14-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Feb. 16, 1955

NAME OF CEMETERY OR CREMATORY Cooley Cemetery

LOCATION (City, town, or county) (State) Near Mouth of Seneca, W. Va.

DATE REC'D BY LOCAL REG. Feb. 14, 1955

REGISTRAR'S SIGNATURE Winter R. Talley, M.D.

24. FUNERAL DIRECTOR Thrush Funeral Home

ADDRESS Petersburg, W. Va.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01108

1113

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 3 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1902 Frederick Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Zihlman Md
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) Anna (Last) Downton

4. DATE OF DEATH: (Month) 2 (Day) 22 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Aug 5th 1869

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home wife

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Eisel

14. MOTHER'S MAIDEN NAME: Martha Baum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Mrs. Stanley Hamilton 1902 Frederick St. Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1 5 3 X

IMMEDIATE CAUSE (A) Advanced Carcinoma of Sternum — INTERVAL BETWEEN ONSET AND DEATH: 9 mos.

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. —

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from May, 1954, to 2/22, 1955, that I last saw the deceased alive on 2/22, 1955, and that death occurred at 1:00 A.M, from the causes and on the date stated above.

SIGNATURE Martin Rothstein M.D. ADDRESS M.D. 48 Broadway - Frostburg, Md DATE SIGNED 2/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2/25/55 — NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park — LOCATION (City, town, or county) (State) Frostburg Md

DATE REC'D BY LOCAL REGISTRAR Feb. 24, 1955 — REGISTRAR'S SIGNATURE Winter K. Frantz M.D.

24. FUNERAL DIRECTOR Jacob Hafer ADDRESS 23 E. Main Frostburg, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1114 **CERTIFICATE OF DEATH** Reg. Dist. No. 01109 7

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL) OR TOWN Cumberland
LENGTH OF STAY (in this place) 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Schiller Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 02
STREET ADDRESS (If rural give location) 14 Schiller Terrace

3. NAME OF DECEASED. (Type or Print) (First) Annie (Middle) (Last) Elrick

4. DATE OF DEATH: (Month) Feb (Day) 24 (Year) 1955

5. SEX F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow | 8. DATE OF BIRTH: May 27, 1872 | 9. AGE last birthday: 82 yrs | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: Own home | 11. BIRTHPLACE (State or foreign country): Barrellsville Md | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Wilhelm | 14. MOTHER'S MAIDEN NAME: Mary Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT & ADDRESS: Mrs Augustus McKenzie, Wellersburg, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

573.0 IMMEDIATE CAUSE (A) Obstruction of Bowels — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSE (S) DUE TO (B) Chronic Constipation — 2 months

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Senility — 82 yr

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: None | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1955, to Feb 24, 1955, that I last saw the deceased alive on Feb 24, 1955, and that death occurred at 7 PM, from the causes and on the date stated above.
SIGNATURE F. Alan G. Murray M. D. ADDRESS Cumberland Md DATE SIGNED Feb 26 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Feb 26, 1955 | NAME OF CEMETERY OR CREMATORY Lutheran Cem | LOCATION (City, town, or county) (State) Wellersburg Md

DATE REC'D BY LOCAL REGISTRAR Feb 26, 1955 | REGISTRAR'S SIGNATURE Walter R. Franke M.D.

24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md

VS. A15—10-53

Within corporate limits

Dr. W. F. Wms

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01110

* 1115 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 1319 Virginia Avenue

3. NAME OF DECEASED: (First) Jessie (Middle) V. (Last) Estes

4. DATE OF DEATH: (Month) Feb. (Day) 15 (Year) 1955

5. SEX: female | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widowed | 8. DATE OF BIRTH December 19 1887 | 9. AGE last birthday 67 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Ownhome
11. BIRTHPLACE (State or foreign country): Virginia, Rapidan
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Printz
14. MOTHER'S MAIDEN NAME: May Jane Weakley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS. Memorial Hospital, Cumberland, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE (S):
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (Adams-Stokes Syndrome)
260 X (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-13, 1938 to 2-15, 1955, that I last saw the deceased alive on 2-15, 1955, and that death occurred at 7:20 PM, from the causes and on the date stated above.
SIGNATURE W. F. Williams M.D. ADDRESS Cumberland DATE SIGNED 2-16-55 Md

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2-18-55 | NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Feb. 17, 1955 | REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md.

VS. A15—10-53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01111

1116 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland
LENGTH OF STAY (in this place) 12/11/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) Florence (Middle) A. (Last) Findlay

4. DATE OF DEATH: (Month) February (Day) 6, (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 4/10/1870

9. AGE last birthday 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Mt. Savage, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Aldridge

14. MOTHER'S MAIDEN NAME: Amanda Leasure

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 IMMEDIATE CAUSE	(A) Hypostatic Congestion	4 days,
ANTECEDENT CAUSE (S)	DUE TO (B) Chronic Myocarditis	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) General arteriosclerosis	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Chronic nephritis	?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 11, 1953 to Feb. 6, 1955, that I last saw the deceased alive on Feb. 5th, 1955 and that death occurred at 1:18 P M, from the causes and on the date stated above.

SIGNATURE Florence B. McLean M.D. ADDRESS 49 Greene St. DATE SIGNED 2-7-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Feb. 8, 1955

NAME OF CEMETERY OR CREMATORY Methodist Cemetery

LOCATION (City, town, or county) (State) Mt. Savage, Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 8, 1955

REGISTRAR'S SIGNATURE Wintes R. Frantz, M.D.

24. FUNERAL DIRECTOR J. R. Durst, Frostburg,

ADDRESS

FEB
BUREAU V. S.

: 1161

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01112 •

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place) 1 Day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W. Va. — COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bery
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) Edward. (Middle) (Last) Flick.

4. DATE OF DEATH: (Month) Feb. (Day) 2- (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Write): Single

8. DATE OF BIRTH: 2/1/55

9. AGE last birthday: 1 day yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: Donna Novella Laye

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Mother — Bery, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity (5 Months) — Interval between Onset and Death: Few Hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) —
(c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1, 1955 to 2/1, 1955, that I last saw the deceased alive on 2/1, 1955, and that death occurred at 1:40 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): John B. Davis, M.D. — ADDRESS: Frostburg, Md. — DATE SIGNED: 2/2/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 2-3-55 — NAME OF CEMETERY OR CREMATORY: Philos Cemetery — LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG.: 2-3-55 — REGISTRAR'S SIGNATURE: Dr. Harry N. Poe — 24. FUNERAL DIRECTOR: Ellsworth Boal — ADDRESS: Westernport, Md.

2 : 30 25

RECEIVED
FEB 7 19
BURF

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1 01113

1117 CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hosp. 60

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE W. Va. — COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgeley
STREET ADDRESS (If rural give location) 66 Potomac St.

3. NAME OF DECEASED: (Type or Print) (First) Ralph (Middle) (Last) Frantz

4. DATE OF DEATH: (Month) Feb. (Day) 4, (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced

8. DATE OF BIRTH: May 3, 1903

9. AGE last birthday: 51 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Owner Super Market

10b. KIND OF BUSINESS OR INDUSTRY: Grocery

11. BIRTHPLACE (State or foreign country): Connellsville, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas P. Frantz

14. MOTHER'S MAIDEN NAME: Minnie B. Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mrs. Minnie Frantz Ridgeley, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause (a) Coronary Thrombosis DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: Several Hrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypostatic pneumonia

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-4, 1955, to 2-6, 1955, that I last saw the deceased alive on 2-4, 1955, and that death occurred at 11 PM, from the causes and on the date stated above.

SIGNATURE W. K. Williamson (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 2-6-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2-7-1955 — NAME OF CEMETERY OR CREMATORY Blooming Rose Cem. — LOCATION (City, town, or county) (State) Friendsville, Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 6, 1955 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR Charles L. George — ADDRESS Cumberland, Md.

VS. A15

FEB
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1118

CERTIFICATE OF DEATH

01114

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Cumberland, Md.
LENGTH OF STAY (in this place) 30yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 321 Massachusetts Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
STREET ADDRESS (If rural give location) 321 Massachusetts Ave.

3. NAME OF DECEASED: (First) Belle (Middle) (Last) Gano
4. DATE OF DEATH: (Month) (Day) (Year) 2-2-1955 19

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug 1, 1874
9. AGE last birthday: 80 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Ownhome
11. BIRTHPLACE (State or foreign country): Morgan County W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathan Hovermale
14. MOTHER'S MAIDEN NAME: Lucinda Bohrer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs. E. Lee Keiter 321 Mass. Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uraemia — Interval Between Onset And Death: 3 wks.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Chronic Myocarditis — 5 yrs.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. ,1954, to Feb. 2, ,1955, that I last saw the deceased alive on Feb. 1, ,1955, and that death occurred at ..... ., from the causes and on the date stated above.

SIGNATURE Clark R. Burrett (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 2/3/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2-5-55
NAME OF CEMETERY OR CREMATORY Hebron Cem.
LOCATION (City, town, or county) (State) Winchester, Va.

DATE REC'D BY LOCAL REGISTRAR Feb. 4, 1955
REGISTRAR'S SIGNATURE Walter R. Trenty, M.D.
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli Cumberland, Md.

VS. A15

DIVI
ED
BUREAU U. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 1119 **CERTIFICATE OF DEATH** Reg. Dist. No. 01115 4

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH. COUNTY Allegany — MARYLAND — CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland — LENGTH OF STAY (in this place) — HOSPITAL OR INSTITUTION OR STREET ADDRESS 212 Fulton St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland STREET ADDRESS (If rural give location) 212 Fulton St.

3. NAME OF DECEASED: (First) William (Middle) Hayes (Last) Gatehouse

4. DATE OF DEATH: (Month) 2 (Day) 22 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 3/10/1877

9. AGE last birthday 77 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk

10B. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.

11. BIRTHPLACE (State or foreign country): Frostburg Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Gatehouse

14. MOTHER'S MAIDEN NAME: Sarah Jane Gatehouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-05-8170

17. INFORMANT & ADDRESS: Mrs. W. H. Gatehouse

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE 420.1	(A) Arteriosclerosis	10 yrs
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Chronic Myocarditis	5 yrs
	DUE TO (C) Cerebral Hemorrhage	2 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

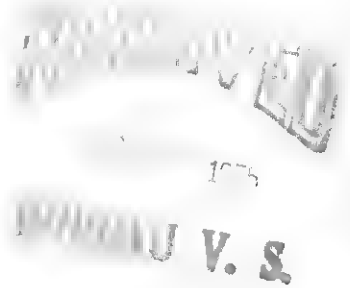
22. I hereby certify that I attended the deceased from 2/10/, 1955 to 2/22/, 1955; that I last saw the deceased alive on 2/21/, 1955; and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Clay E. Lowman M. D. — ADDRESS Cumberland — DATE SIGNED 2/24/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2/25/55 — NAME OF CEMETERY OR CREMATORY Lewisburg Cemetery — LOCATION (City, town, or county) Lewisburg, Pa. (State)

DATE REC'D BY LOCAL REGISTRAR Feb. 24, 1955 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR John I. Hafer, Sr. — ADDRESS Cumberland

VS. A15 — 10 - 53



DR. HALLINAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01116

1120 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY ALLEGANY — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 3 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE W.VA. COUNTY Mineral
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY
STREET ADDRESS (If rural give location) 159 Main St.,

3. NAME OF DECEASED: (Type or Print) (First) RUBYE (Middle) Louvenia (Last) GRANT

4. DATE OF DEATH: (Month) FEB. (Day) 25 (Year) 1955

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED
8. DATE OF BIRTH: MAY 5, 1902
9. AGE last birthday: 52 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Dept. store
11. BIRTHPLACE (State or foreign country): W.VA. Huttonsville
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: MARTIN V. HIGGS
14. MOTHER'S MAIDEN NAME: ARBELIA SCOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-8361
17. INFORMANT & ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE: 442X
(A) Uremic Toxemia — INTERVAL BETWEEN ONSET AND DEATH: 6 Da.

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Cardio Vascular - Renal Disease — 5 years
(C) DUE TO Hypertensive Heart Disease — 5 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Secondary Anemia

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.): None
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State): None
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.: None
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 13, 19 54, to Feb. 25, 19 55, that I last saw the deceased alive on Feb. 25, 19 55, and that death occurred at 1:05 A. M. from the causes and on the date stated above.
SIGNATURE J. Vaccinow M.D. M.D. ADDRESS 110 Bedford St. Cumberland, Md. DATE SIGNED 2/26/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 2/28/55
NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 27, 1955
REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR: H. Wayne George
ADDRESS: Cumberland, Md.

RECEIVED
MAR 4 1955
BUREAU V. S.

1167

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 01117

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town) Rural) Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS B&O.R.Ry.tracks at Locust Grove

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural, give location) 509 Valley St. 02 1

3. NAME OF DECEASED: (Type or Print) (First) Lawrence (Middle) (Last) Griffin

4. DATE OF DEATH (Month) Feb. (Day) 7 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	Married	July 2-1892	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Furloughed) Boilermaker	B&O.R.Ry.	Trenton, Mo.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Dennis Griffin	Margaret Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	705-05-5531	(wife) Oranda Stevens Griffin, City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) 802X Intrathoracic hemorrhage due to a crushed	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) chest & intra-abdominal hemorrhage due to a crushed pelvis and fractured spine also	Sudden
	DUE TO (c) had fractured bones, face, hands, right humerous and left lower leg, contusions & abrasions of body.	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hit by a B&O.R.Ry freight engine.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. (City or town) (County) (State)
	R.R. tracks	Rural) Locust Grove Allegany Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
Feb.7/55.P. M.		Tried to get across tracks before train arrived, hit by engine

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V. Deming M.D. M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED Feb.7-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 10 1955	Rose Hill Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 9, 1955	Wintes L. Trauth, M.D.	Charles L. George,	"

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01118

1162 CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport
LENGTH OF STAY (In this place) 38 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 221 Bloomington Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport, Rt
STREET ADDRESS (If rural give location) 221 Bloomington Road

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) Martin (Last) Grimm
4. DATE OF DEATH: (Month) Feb (Day) 10 (Year) 1955
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Nov 13, 1870
9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Coal Mine
11. BIRTHPLACE (State or foreign country): Deer Park, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: 221 Bloomington Rd Mrs Nora Grimm, Westernport, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 Days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Myocarditis and Cardiac Insufficiency — 8 Years

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) None
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1918, to Feb. 10, 1955, that I last saw the deceased alive on Feb. 10, 1955, and that death occurred at 3:30 P. M, from the causes and on the date stated above.
SIGNATURE Paul R. Wilson M. D. ADDRESS Piedmont, W. Va DATE SIGNED Feb. 11, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 2-13-55
NAME OF CEMETERY OR CREMATORY: Philos Cem
LOCATION (City, town, or county) (State): Westernport, Md

DATE REC'D BY LOCAL REGISTRAR: 2-12-55
REGISTRAR'S SIGNATURE: Mrs Jean C. Kelly
24. FUNERAL DIRECTOR: Wm E. S. Boor ADDRESS: Westernport, Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

RECEIVED
FEB 1 1 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01119

DR, SIMONS 1121 from 1" film C17 -24-55 L

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
MARYLAND
LENGTH OF STAY (in this place) 22 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 612 ELM Street

3. NAME OF DECEASED: (Type or Print) (First) HARRY (Middle) J. (Last) GURLEY

4. DATE OF DEATH (Month) FEB. (Day) 1 (Year) 1955

5. SEX MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED

8. DATE OF BIRTH. OCT. 8 1889

9. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min. 65 yrs

10A. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED) Retired Installed meters

10B. KIND OF BUSINESS OR INDUSTRY: Potomac Edison Co

11. BIRTHPLACE (State or foreign country) MD. Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS J. GURLEY

14. MOTHER'S MAIDEN NAME: LEOTA EXLER Emma Brotemarkle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO 214-10-5317

17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE 420.1 (A) Coronary Occlusion

ANTECEDENT CAUSE (B) DUE TO (B) Congestive Heart failure

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C) Myocardial degeneration Hardening

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. , 19 54, to 2/1 , 19 55, that I last saw the deceased alive on 2/1 , 19 55, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

SIGNATURE George M. Brown M. D. ADDRESS Cumberland, Md. DATE SIGNED 2/1/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Feb 4 1955

NAME OF CEMETERY OR CREMATORY Greenmount Cemetery

LOCATION (City, town, or county) (State) Cumberland Md

DATE REC'D BY LOCAL REGISTRAR Feb. 3, 1955

REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01120

1122

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
MARYLAND — LENGTH OF STAY (in this place): 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 640 N. Center St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 640 N. Center St.

3. NAME OF DECEASED (Type or Print): (First) Julius (Middle) Ray (Last) Hanline

4. DATE OF DEATH: (Month) Feb (Day) 25 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W	Married	Sept. 21, 1900	54 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner
10B. KIND OF BUSINESS OR INDUSTRY: Coal Mines
11. BIRTHPLACE (State or foreign country): Horse Shoe Run, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Hanline
14. MOTHER'S MAIDEN NAME: Effie Sell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.W.I
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Lottie Hanline, Cumberland, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

5' 7.1
IMMEDIATE CAUSE (A) Cor Pulmonale
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Emphysema & Interstitial Fibrosis
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: **19B. MAJOR FINDINGS OF OPERATION**
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/29, 1954, to 2/25, 1955, that I last saw the deceased alive on 2/10, 1955, and that death occurred at 6 A. M, from the causes and on the date stated above.

SIGNATURE: Jos N. Ley Jr. M. D. ADDRESS: 456 N. Center St. DATE SIGNED: 2/26/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 27, 1955	Texas Cemetery	Horse Shoe Run, W. Va.

DATE REC'D BY LOCAL REGISTRAR: Feb. 26, 1955
REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR James Kemple ADDRESS: Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01121

1123 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 12/15/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg,
STREET ADDRESS (If rural give location) 11 Beall Street

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) (Last) Hartig

4. DATE OF DEATH (Month) (Day) (Year) February 28, 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 3/30/1875

9. AGE last birthday: 79 yrs
IF UNDER 1 YEAR, Months / Days; IF UNDER 24 HRS., Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Andrew Hartig

14. MOTHER'S MAIDEN NAME: Elizabeth Baum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
42.2.2 IMMEDIATE CAUSE	(A) Chronic Myocardial Degeneration	?
ANTECEDENT CAUSE (S)	DUE TO (B) Cerebral Arteriosclerosis	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) Pulmonary Congestion	3 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Senile psychosis,	2 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 15, 1954, to Feb. 28, 1955, that I last saw the deceased alive on Feb. 27, 1955, and that death occurred at 2:15A M, from the causes and on the date stated above.

SIGNATURE James R. McLean M.D. ADDRESS 49 Pine St. DATE SIGNED 2-28-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF March 2, 1955

NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park

LOCATION (City, town, or county) (State) Frostburg, Maryland

DATE REC'D BY LOCAL REGISTRAR March 1, 1955

REGISTRAR'S SIGNATURE Wintes R. Beauty, M.D.

24. FUNERAL DIRECTOR J. R. Hurst

ADDRESS Frostburg, Maryland

RECEIVED
MAR 4 1955
BUREAU

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01122

• 1168 CERTIFICATE OF DEATH Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt. Savage
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Foundry Row

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage X
STREET ADDRESS (If rural give location) Foundry Row

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) Elizabeth (Last) Hice

4. DATE OF DEATH: (Month) Feb. (Day) 5 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: I/16/1862

9. AGE last birthday: 93 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Jenkins

14. MOTHER'S MAIDEN NAME: Sarah Kalklesser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs Warren Hice Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Hypostatic Congestion Lung — 3 Days

ANTECEDENT CAUSE (S) DUE TO Senility — 9 3 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

(INTERVAL BETWEEN ONSET AND DEATH)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Bedsores

19A. DATE OF OPERATION. None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1954 to Feb 5th, 1955, that I last saw the deceased alive on Feb 5, 1955, and that death occurred at 5 P. M, from the causes and on the date stated above.

SIGNATURE F. Alan L. Winn M. D. ADDRESS Cumberland Md DATE SIGNED Feb 6/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2/8/1955 — NAME OF CEMETERY OR CREMATORY St. George Episcopal — LOCATION (City, town, or county) Mt. Savage (State) Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 7, 1955 — REGISTRAR'S SIGNATURE Veronica McDermott

24. FUNERAL DIRECTOR Louis Stein, Inc. — ADDRESS Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01123

1124 CERTIFICATE OF DEATH Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 38 Humbird St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland; STREET ADDRESS (If rural give location) 38 Humbird St.

3. NAME OF DECEASED: (First) Eleanor (Middle) Gullatt (Last) Hiett

4. DATE OF DEATH: (Month) 2 (Day) 23 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed | 8. DATE OF BIRTH: 10/6/1872 | 9. AGE last birthday: 82 yrs | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: Own Home | 11. BIRTHPLACE (State or foreign country): Lucketts, Va. Loudon Co | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Conrad | 14. MOTHER'S MAIDEN NAME: Annie Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT & ADDRESS. Thomas W. Reckley - 107 Elder St. Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO arteriosclerotic heart disease — 2 years

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. upper respiratory infection — 2 weeks

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-22-, 1955, to 2-23, 1955, that I last saw the deceased alive on 2-22-, 1955, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

SIGNATURE L. Bruno M.D. ADDRESS 52 Greene St. DATE SIGNED 2-24-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF 2/25/55 | NAME OF CEMETERY OR CREMATORY Enon Baptist Cem. | LOCATION (City, town, or county) Largent, W. Va. (State)

DATE REC'D BY LOCAL REGISTRAR Feb. 24, 1955 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR John J. Hafer, Sr. | ADDRESS Cumberland, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1125

CERTIFICATE OF DEATH

Reg. Dist. No. 01124

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
LENGTH OF STAY (in this place) 62 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 705 HILL TOP DRIVE

3. NAME OF DECEASED: (Type or Print) (First) ELLA (Middle) Frances (Last) HOFFMAN

4. DATE OF DEATH: (Month) FEB. (Day) 27 (Year) 1955

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED
8. DATE OF BIRTH. JUNE 12, 1884
9. AGE last birthday 70 yrs. IF UNDER 1 YEAR Months / Days IF UNDER 24 HRS. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Cumberland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: HENRY FOUCHTMAN
14. MOTHER'S MAIDEN NAME: ANNA FOX

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: James Hoffman - Cumberland Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Carcinoma breast - left advanced — INTERVAL BETWEEN ONSET AND DEATH: 2-3 years
ANTECEDENT CAUSE (S) DUE TO (B) Cachexia secondary to Carcinoma — 6 months.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) ~~Cachexia~~

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic Vascular disease

19A. DATE OF OPERATION Feb 12, 1955
19B. MAJOR FINDINGS OF OPERATION amputation ulcerated left breast
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 27, 1955 to Feb 27, 1955 that I last saw the deceased alive on Feb 27, 1955, and that death occurred at 10:25 AM from the causes and on the date stated above.
SIGNATURE W W Faw M.D. ADDRESS Cumberland Md DATE SIGNED Feb 28 1955

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 3/2/55
NAME OF CEMETERY OR CREMATORY St Marys Catholic Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REGISTRAR March 1, 1955
REGISTRAR'S SIGNATURE Victor R. Krantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

RECEIVED
MAR 4 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1126

CERTIFICATE OF DEATH

Reg. Dist. No. 4 01125

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

1. PLACE OF DEATH. COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Cumberland
LENGTH OF STAY (in this place) 6/2/51
HOSPITAL OR INSTITUTION OR STREET ADDRESS 11 Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 25 Mullin Street

3. NAME OF DECEASED: (First) Edgar (Middle) Franklin (Last) Imes
4. DATE OF DEATH: (Month) February (Day) 25, (Year) 19 55

5 SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8 DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	10/31/1884	70 yrs				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	Fairchilds, Hagerstown	Pennsylvania-Bedford County	U. S. A.

13. FATHER'S NAME: Alfred Imes
14. MOTHER'S MAIDEN NAME: Nancy Potts

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT & ADDRESS:
NO	215-20-7949	Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4 or 2.1 IMMEDIATE CAUSE	(A) Chronic Myocarditis	?
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) General Arteriosclerosis	?
	DUE TO (C) Parkinsons Disease	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Senility	1 year

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Jan 2, 1955 to Feb 20, 1955 that I last saw the deceased alive on Feb 24, 1955, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Ernest E Tschan M. D. ADDRESS 49 Green St. DATE SIGNED 2-25-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Buried	Feb 26, 1955	Bethel Cemetery	Cheneyville, Pa

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 26, 1955	Wesley R. Frantz, M.D.	John J. Hafer, Cumberland Md	

within the corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01126

1127

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
MARYLAND LENGTH OF STAY (in this place) 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Near Cumberland, rural
STREET ADDRESS (If rural give location) R.F.D. #6, Bowling Green

3. NAME OF DECEASED. (Type or Print) (First) Fred. (Middle) Marie (Last) Klipstein

4. DATE OF DEATH: (Month) 2 (Day) 14 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 2/2/55

9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days 12 IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sherman Klipstein

14 MOTHER'S MAIDEN NAME: Eva Skelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Patient's Chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

134.3 IMMEDIATE CAUSE (A) Pulmonia — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSE (B) DUE TO Clinical T. Mon. Inf. — 2 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Nil

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/11, 1955, to 2/14, 1955, that I last saw the deceased alive on 2/13, 1955, and that death occurred at 5:54 M. from the causes and on the date stated above.

SIGNATURE Wm. Carl K. Grimm, M.D. ADDRESS 55 Prince St. DATE SIGNED 2/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 2-16-55

NAME OF CEMETERY OR CREMATORY St. Ambrose Cem.

LOCATION (City, town, or county) (State) Cresaptown, Md

DATE REC'D BY LOCAL REGISTRAR Feb 15, 1955

REGISTRAR'S SIGNATURE Wm. Carl K. Grimm, M.D.

24 FUNERAL DIRECTOR Chas. L. George

ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

2-54 14 16

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01127

1128 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 423 N. Center St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland; STREET ADDRESS (If rural give location) 423 N. Center St.

3. NAME OF DECEASED: (Type or Print) (First) Isabelle (Middle) Christine (Last) Kornhoff

4. DATE OF DEATH: (Month) 2 (Day) 22 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-17-1871

9. AGE last birthday: 83 yrs; IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Cumberland, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mathias Aberle

14. MOTHER'S MAIDEN NAME: Elizabeth Martain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No; (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs. Vernon Hafer 423 Center St. Cumberland, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Occlusion. — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Valvular Heart disease — several years

DUE TO (C) Senility

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. , 1955, to Feb 22 , 1955, that I last saw the deceased alive on Feb 22, 1955, and that death occurred at 6.35 PM, from the causes and on the date stated above.

SIGNATURE F. Alan G. Murray M. D. ADDRESS Cumberland Md DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL; DATE THEREOF 2/25/55; NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery; LOCATION (City, town, or county) (State): Cumberland, Md

DATE REC'D BY LOCAL REGISTRAR Feb 24, 1955; REGISTRAR'S SIGNATURE Winter K. Frantz M.D.

24. FUNERAL DIRECTOR: John Hafer, Sr.; ADDRESS: Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01128

DR. W.F. WILLIAMS 1129

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
MARYLAND
LENGTH OF STAY (In this place) 26 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
STREET ADDRESS (If rural give location) 79 GREENE STREET

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) Margaret (Last) KRAFT

4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 25 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) SINGLE

8. DATE OF BIRTH: JUNE 10, 1874

9. AGE last birthday 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ANDREW KRAFT

14. MOTHER'S MAIDEN NAME: SARAH A. GUTHMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL- CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 IMMEDIATE CAUSE (A) Chronic Nephritis (Uremia) — INTERVAL BETWEEN ONSET AND DEATH: One week

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Chronic Myocardial Degeneration

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-20, 1955, to 2-25, 1955 that I last saw the deceased alive on 2-24-1955 and that death occurred at 4:40 A.M. from the causes and on the date stated above.

SIGNATURE W. F. Williams M.D. ADDRESS Cumberland DATE SIGNED 2/25/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 2/27/55

NAME OF CEMETERY OR CREMATORY Rose Hill Cem.

LOCATION (City, town, or county) Cumberland, Md. (State) Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 27, 1955

REGISTRAR'S SIGNATURE Wm. R. Trautz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1169

CERTIFICATE OF DEATH

01129

Reg. Dist. No. ... .

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Barton
LENGTH OF STAY (in this place) 52 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton X
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED: (Type or Print) (First) Emma (Middle) Amelia (Last) Kyle

4. DATE OF DEATH: (Month) Feb (Day) 14 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widow

8. DATE OF BIRTH: 1 June 1875

9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Franklin Me.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: David Randall

14. MOTHER'S MAIDEN NAME: Rebecca Carver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs George Lauder, Barton, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
260 X IMMEDIATE CAUSE	(A) Coronary Occlusion	2 d.
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Hypertensive Heart	2 d.
	DUE TO (C) Hypertension	2 d.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Diabetic Mellitus	10 yrs.

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9 Feb, 1955, to 14 Feb, 1955, that I last saw the deceased alive on 14 Feb, 1955, and that death occurred at 3P M, from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Lonaconing Md DATE SIGNED 2-16-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2-17-55 — NAME OF CEMETERY OR CREMATORY Laurel Hill Cem — LOCATION (City, town, or county) (State) Barton, Md

DATE REC'D BY LOCAL REGISTRAR 2-17-55 — REGISTRAR'S SIGNATURE Mrs Jean C. Kelly

24. FUNERAL DIRECTOR E.S. Boaz — ADDRESS Westernport, Md.

Within corporate limits

1130

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 01130

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Cumberland — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jane Frazier Village

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) Jane Frazier Village

3. NAME OF DECEASED: (First) John (Middle) (Last) Leasure
4. DATE OF DEATH (Month) Feb. (Day) 3 (Year) 19 55
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Dec. 27-1871
9. AGE last birthday: 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Gen Farming
11. BIRTHPLACE (State or foreign country): (rural) Oldtown, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Isaac Leasure
14. MOTHER'S MAIDEN NAME: Martha Pennell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: (wife) Jane Hamilton Leasure, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Cerebral hemorrhage (apoplexy)	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	Arteriosclerosis with hypertention.	?
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED Feb. 4-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 2/6/55
NAME OF CEMETERY OR CREMATORY Rose Hill Cem
LOCATION (City, town, or county) (State) Cumberland, Md

DATE REC'D BY LOCAL REG. Feb. 5, 1955
REGISTRAR'S SIGNATURE Wynter K. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumb. Md. ADDRESS

VS. A15A - 5 - 53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01131

? 1131

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS SACRED HEART HOSPITAL
MARYLAND LENGTH OF STAY (in this place) 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 1010 BEDFORD STREET

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) WILLIAM (Last) LINDNER

4. DATE OF DEATH: (Month) 2/2/55 (Day) (Year) 19

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH 6/30/89

9. AGE last birthday 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): RETIRED Specialist manufacturing Dept.

10B. KIND OF BUSINESS OR INDUSTRY: CELANESE CORP OF AME CA

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE LINDNER

14. MOTHER'S MAIDEN NAME: FLORENCE BRAMBLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) First WW.

16. SOCIAL SECURITY NO. 214-07-4888

17. INFORMANT & ADDRESS: Sacred Heart Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) DUE TO Cerebral Hemorrhage (2nd) — INTERVAL BETWEEN ONSET AND DEATH 16 hrs

ANTECEDENT CAUSE (B) DUE TO " " (1st) — 5 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertension

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/29/55, 19 , to 2/2/55, 19 , that I last saw the deceased alive on 2/1/55, 19 ... ., and that death occurred at 7:05 A M. from the causes and on the date stated above.

SIGNATURE R. Wallace M. D. ADDRESS Cumberland DATE SIGNED 2/3/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Feb 4 1955 — NAME OF CEMETERY OR CREMATORY St Patricks Cemetery — LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 3, 1955 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Kight — ADDRESS Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01132

1132

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allega ny
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 512 Forester Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 512 Forester Ave

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Louis (Last) Lindner

4. DATE OF DEATH (Month) Feb. (Day) 2 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 3/26/1892

9. AGE last birthday 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10B. KIND OF BUSINESS OR INDUSTRY: City of Cumberland

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Lindner

14. MOTHER'S MAIDEN NAME: Mary Ready

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) War I

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mr. Thomas Lindner 512 Forester Ave.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 422.2 (A) Congestive Heart Failure

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Myocardial Degeneration

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral Hemorrhage (Stroke)

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/19, 1954, to 2/2, 1955, that I last saw the deceased alive on 2/2, 1955, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

SIGNATURE Leo N. Levy Jr. M.D.

ADDRESS 456 N. Centre St.

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 2/5/55

NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 4, 1955

REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein, Inc.

ADDRESS Cumberland, Md.

VS. A15 — 1-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB

Within corporate limits: ? 1133

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 01133

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Mt Savage
STREET ADDRESS (If rural, give location) Main St.

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) Benedict (Last) Logsdon

4. DATE OF DEATH (Month) Feb. (Day) 28 (Year) 1955

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: Feb.1-1875

9. AGE Last birthday: 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Retired-Car repairman

10b. KIND OF BUSINESS OR INDUSTRY: C&P.R.R.y.

11. BIRTHPLACE (State or foreign country): Mt Savage, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Logsdon

14. MOTHER'S MAIDEN NAME: Anna Carlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Shock (senility) — Interval between onset and death: 6 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Cardio-vascular-renal disease — Interval: ?

DUE TO

(c) Intratrochanteric fracture of left femur — Interval: 6 days.

Arteriosclerosis — Interval: ?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐

21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home

21c. (City or town) Mt. Savage (County) Allegany (State) Md.

21d. TIME (Month) (Day) (Year) OF INJURY Feb.22/55 (Hour) P. M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Tried to get out of bed by himself & fell to the floor.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Feb.28 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF March 2, 1955 — NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery — LOCATION (City, town, or county) (State) Mt. Savage, Maryland

DATE REC'D BY LOCAL REG. March 4, 1955 — REGISTRAR'S SIGNATURE Walter L. Beauty, M.D.

24. FUNERAL DIRECTOR Louis Stein, Inc, Cumberland, " — ADDRESS

RECEIVED
MAR 4 1955
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1134

01134

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (In this place) 6/24/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Cash Valley~~ Near, Cumberland, Rural
STREET ADDRESS (If rural give location) Rt. # 1, Cash Valley

3. NAME OF DECEASED: (First) Florence (Middle) E. (Last) Luteman
4. DATE OF DEATH: (Month) February (Day) 22 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 6/30/1871
9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own House
11. BIRTHPLACE (State or foreign country): Dingle Hill, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Michael W. Daugherty
14. MOTHER'S MAIDEN NAME: Joanne McKenzie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 IMMEDIATE CAUSE	(A) Chronic Myocarditis	?
ANTECEDENT CAUSE (B)	DUE TO (B) General arteriosclerosis	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) Pernicious senescia	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Senile deterioration	?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 24 1953, to Feb. 22 1955, that I last saw the deceased alive on Feb. 21, 1955, and that death occurred at 10 a. M, from the causes and on the date stated above.
SIGNATURE Laurence E. McLean Jr. M. D. ADDRESS 49 Green St. DATE SIGNED 2/22/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Feb 25 1955
NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery
LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 24, 1955
REGISTRAR'S SIGNATURE Winter R. Sautz, M.D.
24. FUNERAL DIRECTOR William H. Kight, ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01135

1135

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 9 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 10 MARY STREET

3. NAME OF DECEASED: (Type or Print) (First) MARIE (Middle) ORA (Last) MC ELFISH

4. DATE OF DEATH: (Month) FEB. (Day) 7 (Year) 1955

5. SEX: FEMALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE | 8. DATE OF BIRTH: OCT 17, 1902 | 9. AGE last birthday 52 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10B. KIND OF BUSINESS OR INDUSTRY: Celanese Corp
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ERWIN MC ELFISH
14. MOTHER'S MAIDEN NAME: BERTHA HINKLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) UNK. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-22-5552
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL CUMBERLAND MARYLAND

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Jan. 26, 1955

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Hemiplegia, Left

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 26, 1955 to Feb. 7, 1955 that I last saw the deceased alive on Feb. 7, 1955 and that death occurred at 7:43 P M, from the causes and on the date stated above.

SIGNATURE M. D. Cloyd Durrett ADDRESS Cumberland DATE SIGNED 2/9/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Feb. 10, 1955 | NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 10, 1955 | REGISTRAR'S SIGNATURE Wynton R. Frantz, M.D. | 24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. | ADDRESS

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01136

1170 CERTIFICATE OF DEATH Reg. Dist. No. 6

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Luke
LENGTH OF STAY (in this place) 2½ hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dispensary, Paper Mill

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke X
STREET ADDRESS (If rural give location) 401 Pratt St

3. NAME OF DECEASED: (Type or Print) (First) Wyant (Middle) Kelly (Last) McRobie

4. DATE OF DEATH: (Month) Feb (Day) 16 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: June 18, 1900

9. AGE last birthday 54 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10B. KIND OF BUSINESS OR INDUSTRY: Paper Mill

11. BIRTHPLACE (State or foreign country): Deer Park, Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Joseph H. McRobie

14. MOTHER'S MAIDEN NAME: Clara N. Freeland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-09-3299

17. INFORMANT & ADDRESS: Mrs. W. K. Mc Robie, 401 Pratt St Luke, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
4211
IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) Coronary Sclerosis — 6 Mos
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Recent influenza -

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Wm. Wyatt Paper Co.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 24, 19[illegible], to Feb 16, 1955, that I last saw the deceased alive on Feb 16, 1955, and that death occurred at 11 55 P M, from the causes and on the date stated above.

SIGNATURE Robert W. Bell M.D. ADDRESS Luke, Md DATE SIGNED 2-18-55.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Feb 20, 55 — NAME OF CEMETERY OR CREMATORY Fairview Cemetery — LOCATION (City, town, or county) (State) Oakland, Garrett, Maryland

DATE REC'D BY LOCAL REGISTRAR 2-18-55 — REGISTRAR'S SIGNATURE Mrs Jean C Kelly

24. FUNERAL DIRECTOR E. S. Boal — ADDRESS Westernport, Maryland

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MUSEUM V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01138

DR. SIMONS 1137

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH.
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 21 days
12
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND 02
STREET ADDRESS (If rural give location) 6 DECATUR STREET 1

3. NAME OF DECEASED (Type or Print): (First) ADA (Middle) L (Last) MILLER

4. DATE OF DEATH: (Month) FEBRUARY (Day) 20 (Year) 19 55

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: DECEMBER 11 1892
9. AGE last birthday: 62 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CONRAD MILLER
14. MOTHER'S MAIDEN NAME: MARY NICKEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL-CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE 442X	(A) Uremia	2 months
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(B) Hypertension & Cardiovascular	
DUE TO	(C) Arterial Disease	5 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/ 950, 19 , to 2/ 20, 1955, that I last saw the deceased alive on 2/ 20, 1955, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

SIGNATURE James M Lyon M.D. ADDRESS Cumberland Md. DATE SIGNED 2/20/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Feb. 23, 1955
NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum
LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR: Feb. 23, 1955
REGISTRAR'S SIGNATURE: Winter R. Lantz M.D.
24. FUNERAL DIRECTOR: John J. Hafer, ADDRESS: "

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01137

: 1136 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 4yr.6mo.16days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 410 Robbins Terrace

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) (Last) Minke

4. DATE OF DEATH: (Month) Feb. (Day) 24 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widow

8. DATE OF BIRTH. Sept. 9, 1876

9. AGE last birthday 78 yrs. IF UNDER 1 YEAR Months IF UNDER 24 HRS. Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10B. KIND OF BUSINESS OR INDUSTRY. Own home

11. BIRTHPLACE (State or foreign country) Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Albert Eschenbach

14. MOTHER'S MAIDEN NAME Margaret Bopp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mr. Paul Minke Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (B) Chronic Myocardial Degeneration ?

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (C) Cerebral Arteriosclerosis ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis — 5 1/2 yrs.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1952 to Feb. 24, 1955, that I last saw the deceased alive on Feb. 23, 1955, and that death occurred at 5:30 P M, from the causes and on the date stated above.

SIGNATURE Lucius B. McLaca M.D ADDRESS 49 Greene St. DATE SIGNED 2-24-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 2-27-1955

NAME OF CEMETERY OR CREMATORY Rose Hill Cem.

LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Feb. 24, 1955

REGISTRAR'S SIGNATURE Wister R. Trautz, M.D

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01139

1171

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing
LENGTH OF STAY (in this place) 48 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Douglas Ave

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) 90 Douglas Ave

3. NAME OF DECEASED: (Type or Print) (First) ROBERT (Middle) Ferguson (Last) Mitchell

4. DATE OF DEATH: (Month) Feb (Day) 6 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower

8. DATE OF BIRTH: 22 March 1864

9. AGE last birthday: 90 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner-Ret

10B. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: James Mitchell

14. MOTHER'S MAIDEN NAME: Margeret Ferguson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-12-8769

17. INFORMANT & ADDRESS: Mrs Annie Anderson, Lonaconing, Md 90 Douglas Ave

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4 3 2 1
IMMEDIATE CAUSE (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 d

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Arteriosclerosis, Generalized — 10 years
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1954, to 2/6, 1955, that I last saw the deceased alive on 2/6, 1955, and that death occurred at 7 a M, from the causes and on the date stated above.

SIGNATURE [signature] M.D. ADDRESS Lonaconing Md DATE SIGNED 2-8-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2-9-55 — NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery — LOCATION (City, town, or county) (State) Lonaconing, Md

DATE REC'D BY LOCAL REGISTRAR 2-9-55 — REGISTRAR'S SIGNATURE Jannette M Boal

24. FUNERAL DIRECTOR E. S. Boal — ADDRESS Westernport, Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01140

1138 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cumberland Rural X
STREET ADDRESS (If rural give location) RFD #2 Baltimore Pike

3. NAME OF DECEASED: (Type or Print) (First) MARGARET (Middle) S. (Last) NEUMANN

4. DATE OF DEATH: (Month) 2 (Day) 23 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 2-28-1880

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JACOB SANBACH

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS: Mrs. W. R. FRANTZ, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

32.1X

IMMEDIATE CAUSE (A) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 Weeks

ANTECEDENT CAUSE (B) DUE TO Cerebral arteriosclerosis — 12 mos

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-24, 1954, to 2-23, 1955, that I last saw the deceased alive on 2-23, 1955, and that death occurred at 10:45 A.M., from the causes and on the date stated above.

SIGNATURE Ralph L. Baccini, M.D. ADDRESS 62 Frame St Cumberland Md DATE SIGNED 2-23-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2-26-55 — NAME OF CEMETERY OR CREMATORY Hillcrest Cem. — LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 23, 1955 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS Cumberland, Md.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01141

1163 CERTIFICATE OF DEATH Reg. Dist. No. 9

1. PLACE OF DEATH:
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
MARYLAND LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg 2.
STREET ADDRESS (If rural give location) 42 Green Street

3. NAME OF DECEASED. (Type or Print) (First) Harry (Middle) J. (Last) Pearson

4. DATE OF DEATH. (Month) Feb. (Day) 28th, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: June 16, 1878

9. AGE last birthday. 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never if retired.) Retired Salesman

10B. KIND OF BUSINESS OR INDUSTRY: Eastern States

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Pearson

14. MOTHER'S MAIDEN NAME: Farmers Exchange Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-18-2975

17. INFORMANT & ADDRESS: Mrs. Julia A. Pearson, Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 240.0 (A) DUE TO Senilis Anemia — INTERVAL BETWEEN ONSET AND DEATH 6 mo

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary Sclerosis Hypertension several years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954 to Feb 28 1955, that I last saw the deceased alive on Feb 28, 1955, and that death occurred at 11:00 A.M. from the causes and on the date stated above.

SIGNATURE Wm Lane MD M. D. ADDRESS Frostburg Md DATE SIGNED 3-2-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 3-2-1955

NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park

LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 3-2-55

REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR Joseph R. Durst

ADDRESS Frostburg, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **01142**

1139

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland; MARYLAND; LENGTH OF STAY (in this place) 20 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural give location) 607 Greenway Ave,

3. NAME OF DECEASED: (First) Kennis (Middle) R. (Last) Pfab

4. DATE OF DEATH: (Month) Feb. (Day) 10, (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

8. DATE OF BIRTH: 8/19/68

9. AGE last birthday: 86 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer Retired

10B. KIND OF BUSINESS OR INDUSTRY: Tin Plate Mill

11. BIRTHPLACE (State or foreign country): Carroll County Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Pfab

14. MOTHER'S MAIDEN NAME: Magdaline Hammerline Pfab

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Pt's Chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteriosclerosis — 6 mos.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 1-24-55

19B. MAJOR FINDINGS OF OPERATION: Carcinoma stomach

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-24-55, 19.., to 2-10-55, 19.., that I last saw the deceased alive on 2-10-55, 19.., and that death occurred at 1:50 P.M., from the causes and on the date stated above.

SIGNATURE [illegible] M. D. ADDRESS [illegible] DATE SIGNED 2-11-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-14-55	St Peter & Paul's Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 12, 1955

REGISTRAR'S SIGNATURE: Walter R. Rauh, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland, Md.

VS. A15—10-53

Within corporate limits DR. GROVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01143

1140 CERTIFICATE OF DEATH Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 20 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LITTLE ORLEANS
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) William Henry (Middle) HARRISON (Last) PRICE

4. DATE OF DEATH: (Month) FEB. (Day) 13 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): WIDOWED

8. DATE OF BIRTH: NOV. 15, 1889

9. AGE last birthday 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W. PRICE

14. MOTHER'S MAIDEN NAME: Sarah Creek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W. W. I

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

550.1

IMMEDIATE CAUSE (A) Myocardial failure — 10 Days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Pneumonia — 14 days

DUE TO (C) Perforated appendicitis & peritonitis — 20 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 1-25-55

19B. MAJOR FINDINGS OF OPERATION: Perforated appendicitis & peritonitis

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-24, 1955 to 2-13, 1955, that I last saw the deceased alive on 2-13, 1955, and that death occurred at 12:18 P.M., from the causes and on the date stated above.

SIGNATURE D. R. Grove M.D. ADDRESS Cumberland DATE SIGNED 2-13-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: Feb. 16, 1955 — NAME OF CEMETERY OR CREMATORY: Piney Plains Cem — LOCATION (City, town, or county) (State): Near Hancock, Maryland

DATE REC'D BY LOCAL REGISTRAR: Feb. 14, 1955 — REGISTRAR'S SIGNATURE: Winter R. Lantz, M.D. — 24. FUNERAL DIRECTOR: Howard Groves — ADDRESS: Hancock, Maryland

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01144

1141 CERTIFICATE OF DEATH Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 9 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 802 MICHIGAN AVENUE

3. NAME OF DECEASED: (Type or Print) (First) ESSIE (Middle) MAE (Last) RINGLER

4. DATE OF DEATH: (Month) FEB. (Day) 11 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: NOVEMBER 19, 1898

9. AGE last birthday: 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): HAGERSTOWN, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES CHANEY

14. MOTHER'S MAIDEN NAME: GLORGIA A. TURNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS.: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 X
IMMEDIATE CAUSE (A) Myocarditis – Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 7 Months

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Embolis to right Popliteal Artery — 10 days
DUE TO (C) Diabetes Mellitus — Unknown

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION.

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1955, to Feb, 1955, that I last saw the deceased alive on Feb 11, 1955, and that death occurred at 1:40 P.M., from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS 133 [illegible] DATE SIGNED [illegible]

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 2/14/55

NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 12, 1955

REGISTRAR'S SIGNATURE: Wirt R. Trautz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

1172

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 01145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH: COUNTY Allegany MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) X (Rural) Oldtown; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS About 1/2 mile from Old-town in a field near road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Oldtown X; STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED: (First) Harley (Middle) Merten (Last) Robertson

4. DATE OF DEATH (Month) Feb. (Day) 21 (Year) 19 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	single	Sept 30-1895	59 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Own Farm	Green Ridge, Md.	U.S.A.

13. FATHER'S NAME: Enos E. Robertson

14. MOTHER'S MAIDEN NAME: Mary Virginia Keefer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no		(sister) Goldie May Dolan, Oldtown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (INTERVAL BETWEEN ONSET AND DEATH)

9" X

Immediate cause (a) Cerebral hemorrhage due to — sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) laceration of the brain from a 12 guage

DUE TO

(c) shotgun wound in left side of neck.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY near road	21c. (City or town) (near) Oldtown (County) Allegany (State) Md.
21d. TIME (Month) (Day) (Year) OF INJURY Feb. 21/55 (Hour) 10:30 A. M.	21e. INJURY OCCURRED While at work ☒ Not while at work ☐	21f. HOW DID INJURY OCCUR? Used stick to push trigger on shot gun.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H. V. Deming M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED Feb. 21-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 24, 1955	Greenridge Cemetery	Greenridge, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 22, 1955	Mrs. Fay Duckworth	Louis Stein, Inc.	Cumberland, Maryland

Stein

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01146

1142 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 913 Frederick St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 913 Frederick St

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) Catherine (Last) ROMAN

4. DATE OF DEATH: (Month) 2 (Day) 22 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: OCT. 27 - 1885

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): HANCOCK MARYland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph GARLICK

14. MOTHER'S MAIDEN NAME: EVA Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: John R. ROMAN

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (B) DUE TO Arteriosclerotic Heart Disease — 3 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-24, 1954, to 2-22, 1955, that I last saw the deceased alive on 2-22, 1955, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

SIGNATURE Ralph W. Bucci M.D. ADDRESS 62 Greene St Cumberland Md DATE SIGNED 2-23-55

23 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2-26-55 | NAME OF CEMETERY OR CREMATORY Rose Hill Cem | LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 23, 1955 | REGISTRAR'S SIGNATURE Winter L. Fauntz, M.D.

24. FUNERAL DIRECTOR ADDRESS Louis Stein Inc., Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

1164 01147

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 45 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural) Frostburg X
STREET ADDRESS (If rural, give location) R.F.D.#2 Finzel road.

3. NAME OF DECEASED: (First) Anna (Middle) Elizabeth (Last) Rosenberger
4. DATE OF DEATH (Month) Feb. (Day) 7 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	single	April 30-1870	84 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housework		Garrett Co. Md.	U.S.A.

13. FATHER'S NAME: Godfrey Rosenberger
14. MOTHER'S MAIDEN NAME: Margaret Bittner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	Frostburg, Md. (brother) James Rosenberger, R.F.D. #2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause (a)	Bronchial pneumonia	about 7 days.
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)	Asthenia & senility also had	
DUE TO		
(c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Fracture of left femur at surgical neck. Dec.8-1954

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
	None	R(Rur)R.F.D.#2 Frostburg Allegany Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐*	21f. HOW DID INJURY OCCUR?
Dec.8/54-9 A.M.		Tripped over end of linoleium rug in kitchen.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V.Deming M.D. M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED Feb.8-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-10-1955	Finzel Cemetery	Garrett County, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-10-55	Mrs. Nancy N. Roe	J. R. Durst, Frostburg, Md.	

VS. A15A - 5 - 53

Within corporate limits

DR. GARDNER

01148

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1143 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 CUMBERLAND; LENGTH OF STAY (in this place) 2 MO, 5 DAYS; HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND; STREET ADDRESS (If rural give location) 206 BEDFORD ST.

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) E. (Last) RYLAND

4. DATE OF DEATH (Month) FEB. (Day) 19 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) SINGLE

8. DATE OF BIRTH: NOVEMBER 3, 1884

9. AGE last birthday: 70 yrs. | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never just "retired"): Book keeper retired – Laundry

10B. KIND OF BUSINESS OR INDUSTRY: Cumberland

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES L. RYLAND

14. MOTHER'S MAIDEN NAME: BRIDGET DOBSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 220-03-7887

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

J21X

IMMEDIATE CAUSE (A) DUE TO: Cerebral Hemorrhage, right side — Jan 13, 1954 to Feb 19, 1955

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO: Generalized Arteriosclerosis — about 5 yrs

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 16, 1954 to Feb 19 1955, that I last saw the deceased alive on Feb. 19 1955 and that death occurred at 6:15P M, from the causes and on the date stated above.

SIGNATURE T. V. Johnson Jr. M.D. ADDRESS Cumberland Md DATE SIGNED 2-21-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 2-23-55

NAME OF CEMETERY OR CREMATORY St Patricks Cem.

LOCATION (City, town, or county) Cumberland Md. (State)

DATE REC'D BY LOCAL REGISTRAR Feb. 21, 1955

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Lomas Stem Inc

ADDRESS " "

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01149

DR. ELIASON 1144 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

C1F211436

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 5 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 1005 LEXINGTON AVENUE

3. NAME OF DECEASED: (Type or Print) DONNA J. SEYMOUR

4. DATE OF DEATH (Month) FEBRUARY (Day) 6, (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE

8. DATE OF BIRTH: JAN. 8, 1955

9. AGE last birthday: yrs. Months Days 28 IF UNDER 1 YEAR Hours Min. IF UNDER 24 HRS

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SEYMOUR, ROBERT C.

14. MOTHER'S MAIDEN NAME: GERALDINE I. BRANT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

760.0 IMMEDIATE CAUSE (A) Cerebral Injury - DUE TO

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 29 days -

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-1, 1955 to 2-6, 1955, that I last saw the deceased alive on 2-5, 1955, and that death occurred at 3:35 A.M., from the causes and on the date stated above.

SIGNATURE: J. W. Eliason M.D. ADDRESS 126 Union St. Cumberland Md DATE SIGNED 2/6/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 2-7-55

NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 7, 1955

REGISTRAR'S SIGNATURE: Walter R. Faulk, M.D.

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli Cumberland, Md.

FEB
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01150

1145 CERTIFICATE OF DEATH Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 4 mon. 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS SACRED HEART HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 518 PINE Avenue

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) S. (Last) SIPLEY

4. DATE OF DEATH: (Month) (Day) (Year) 2/16/55 19

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married | 8. DATE OF BIRTH 5/26/16 | 9. AGE last birthday 38 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: Own Home | 11. BIRTHPLACE (State or foreign country): Pa. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John R. Elbin | 14. MOTHER'S MAIDEN NAME: Willie [redacted] F. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No. (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT & ADDRESS: Old chart and husband

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

199.5
IMMEDIATE CAUSE (A) [redacted] Carcinomatosis (ovary & colon), months
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) [redacted] DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at 7:45 A.M, from the causes and on the date stated above.

SIGNATURE B. M. Schindler M. D | ADDRESS 41 Greene St Cumberland | DATE SIGNED Feb 16 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Feb. 19 1955 | NAME OF CEMETERY OR CREMATORY Fairview Christian Cem. | LOCATION (City, town, or county) (State) Near Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 17, 1955 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR John J. Hafer | ADDRESS Cumberland, Maryland

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

Within corporate limits

01151

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. ~~JACOBSON~~ 1146 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY: ALLEGANY — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
LENGTH OF STAY (in this place): 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 30 MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: MARYLAND — COUNTY: ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
STREET ADDRESS (If rural give location): 236 PACA STREET

3. NAME OF DECEASED. (Type or Print): (First) GEORGE (Middle) E. (Last) SNYDER

4. DATE OF DEATH: (Month) FEBRUARY (Day) 16 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: JULY 26 1883

9. AGE last birthday: 71 yrs | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Brewery

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE W. SNYDER

14. MOTHER'S MAIDEN NAME: SALLY WEEKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-03-8651

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
IMMEDIATE CAUSE — (A) DUE TO: Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO: Hypertensive V.D. Disease — 1 yrs
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at 6:07A M, from the causes and on the date stated above.

SIGNATURE: B M Schindler M.D. — ADDRESS: 41 Lenark — DATE SIGNED: 2/16/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-19-1955	Rose Hill Cem.	Cumberland.Md

DATE REC'D BY LOCAL REGISTRAR: Feb. 19, 1955 — REGISTRAR'S SIGNATURE: Walter R. Wantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

White corporate limits

MARYLAND 1147 01152

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY If outside corporate limits, write RURAL and give nearest town OR TOWN Cumberland — LENGTH OF STAY (In this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) St. Marys Terrace

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) M. (Last) Steele

4. DATE OF DEATH: (Month) February (Day) 23 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 2, 1906

9. AGE last birthday: 48 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter S. Smith

14. MOTHER'S MAIDEN NAME: Agnes Weir

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS: Attends Chart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Glomerular Nephritis — Interval between onset and death: 2-3 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (1) Uremia. — 2-3 mos.

(c) (2) Left Ventricular Hypertrophy.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (3) Congestive Heart Failure.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 16, 1955 to Feb. 23, 1955, that I last saw the deceased alive on Feb. 23, 1955 and that death occurred at 9:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. ADDRESS Lonaconing DATE SIGNED 2-24-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Feb. 26, 1955 | NAME OF CEMETERY OR CREMATORY: Philos Cemetery | LOCATION (City, town, or county) (State): Western Port, Maryland

DATE REC'D BY LOCAL REG.: Feb. 24, 1955 | (REGISTRAR'S SIGNATURE) Walter L. Frantz, M.D. | 24. FUNERAL DIRECTOR: George Eichhorn, Lonaconing | ADDRESS "

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01153

DR. R. J. WILLIAMS 1148

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 1 HR. 40 MIN.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 65 OFFUTT STREET

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) Thomas (Last) STEVENS

4. DATE OF DEATH: (Month) FEBRUARY (Day) 9 (Year) 1955

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH. APRIL 26, 1891

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman

10B. KIND OF BUSINESS OR INDUSTRY: B. and O. R.R. Co.

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARSHALL STEVENS

14. MOTHER'S MAIDEN NAME: ELLA — Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

3-1X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertension

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/9/55, 19 , to 2/9/55, 19 , that I last saw the deceased alive on 2/9/55, 19 ..., and that death occurred at 11:30 P.M. from the causes and on the date stated above.

SIGNATURE [signature] M.D. ADDRESS Cumberland DATE SIGNED 2/10/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 2/12/55 — NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 11, 1955 — REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein, Inc. — ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01154

1165 **CERTIFICATE OF DEATH** Reg. Dist. No. 9

1. PLACE OF DEATH.
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
LENGTH OF STAY (in this place) 22
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital 61

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Frostburg X
STREET ADDRESS (If rural, give location) Borden Shaft Rt. 1 1

3. NAME OF DECEASED: (Type or Print) (First) Isaac (Middle) Nelson (Last) Sweitzer

4. DATE OF DEATH: (Month) 2 (Day) 19 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widower

8. DATE OF BIRTH: 3-12-1879

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner (Retired)

10B. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Little Orleans, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Henry Sweitzer

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-12-8764

17. INFORMANT & ADDRESS: Benjamin Sweitzer R.D.#1 - Frostburg Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 443X (A) Hypertensive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 YRS.

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: ✓

19B. MAJOR FINDINGS OF OPERATION ✓

20. AUTOPSY? YES ☐ NO ☒ ✓

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ✓

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ✓

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ✓

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ✓

21E. INJURY OCCURRED While at work ☐ Not while at work ☐ ✓

21F. HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from JUNE, 1954, to 2/19, 1955, that I last saw the deceased alive on 2/19/55, 19 ....., and that death occurred at 4:55A. M, from the causes and on the date stated above.

SIGNATURE Martin L. Rothstein M.D. ADDRESS M. D. 48 Broadway - Frostburg, Md. DATE SIGNED 2/19/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2/21/55 — NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park — LOCATION (City, town, or county) (State) Frostburg Md

DATE REC'D BY LOCAL REGISTRAR 2-21-55 — REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR Jacob Hafer — ADDRESS 23 E. Main Frostburg, Md

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RE
FEB
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1149 **CERTIFICATE OF DEATH** 01155

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
MARYLAND
LENGTH OF STAY (In this place) 5 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 126 VIRGINIA AVENUE

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) Catherine (Last) TRAINER

4. DATE OF DEATH: (Month) FEB. (Day) 15 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) SINGLE

8. DATE OF BIRTH: DEC. 7 1886

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Floor Maid

10B. KIND OF BUSINESS OR INDUSTRY: Memorial Hospital

11. BIRTHPLACE (State or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES TRAINER

14. MOTHER'S MAIDEN NAME: NANCY SMITH

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-30-0431

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Cardiac decompensation
(C) Myocardial degeneration

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/10, 1955, to 2/15, 1955, that I last saw the deceased alive on 2/15, 1955, and that death occurred at 3:35 A.M. from the causes and on the date stated above.

SIGNATURE George M. Larmore M.D. ADDRESS Cumberland Md DATE SIGNED 2/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: Feb 17 1955

NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REGISTRAR: Feb. 16, 1955

REGISTRAR'S SIGNATURE: Walter R. Lautz, M.D.

24. FUNERAL DIRECTOR: William H. Kight ADDRESS: Cumberland, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within ~~corporate~~ limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1 1156

1150

DR. R.J. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 8 HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLDTOWN, rural
STREET ADDRESS (If rural give location) Route #1.

3. NAME OF DECEASED: (Type or Print) (First) HERMAN (Middle) C. (Last) TWIGG

4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 19, 1955

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED

8. DATE OF BIRTH: NOV. 29 1895

9. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 59 yrs

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinest

10B. KIND OF BUSINESS OR INDUSTRY Baltimore & Ohio RR

11. BIRTHPLACE (State or foreign country) OLDTOWN, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LURENZO TWIGG

14. MOTHER'S MAIDEN NAME: VELERAH ROBINETTE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-12-8799

17. INFORMANT & ADDRESS. MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 22½

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(A) DUE TO Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 10 hrs

(B) DUE TO —

(C) —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 19 55 19, to Feb 19 55 19, that I last saw the deceased alive on Feb 19 55, 19, and that death occurred at 11:25 P.M. from the causes and on the date stated above.

SIGNATURE O. H. Williams M. D. ADDRESS Cumberland DATE SIGNED 2/20/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Feb 22 1955

NAME OF CEMETERY OR CREMATORY Oldtown Cemetery

LOCATION (City, town, or county) (State) Oldtown Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 22, 1955

REGISTRAR'S SIGNATURE Winter R. Fantz, M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

Within corporate limits

, 1151

01157
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 02 Cumberland
LENGTH OF STAY (in this place) 64 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 913 Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 913 Maryland, Ave.

3. NAME OF DECEASED: (Type or Print) (First) Willard (Middle) J. (Last) Twigg
4. DATE OF DEATH (Month) Feb. (Day) 6 (Year) 19 55
5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH: Feb 22-1890
9. AGE last birthday: 64 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William A Twigg
14. MOTHER'S MAIDEN NAME: Alice Schyrock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-32-3518
17. INFORMANT & ADDRESS: (wife) Alice Mae Towers Twigg, City.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary occlusion — Interval between onset and death: sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Coronary sclerosis — several months.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED Feb. 7-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 2-9-55
NAME OF CEMETERY OR CREMATORY Glendale Cem.
LOCATION (City, town, or county) (State) Flintstone, Md.

DATE REC'D BY LOCAL REG. Feb. 9 1955
REGISTRAR'S SIGNATURE Writes K. Fraley, M.D.
24. FUNERAL DIRECTOR Charles L. George
ADDRESS Mount, Md.

VS. A15A - 5 - 53

WHITE COPY—DR. SIMMONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01158

1152 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LAVALE, MD.
STREET ADDRESS [redacted] (If rural give location)

3. NAME OF DECEASED: (Type or Print) [redacted], MILLICENT [redacted] (First) (Middle) Twigg (Last)

4. DATE OF DEATH: (Month) FEB. (Day) 27 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED

8. DATE OF BIRTH: APRIL 5 1906

9. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min. 48 [redacted] yrs

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10B. KIND OF BUSINESS OR INDUSTRY: Restrauant

11. BIRTHPLACE (State or foreign country): PENNA. Meyersdale

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM KALLMYER

14. MOTHER'S MAIDEN NAME: EMMA LEWIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-24-0844

17. INFORMANT & ADDRESS: Memorial Hospital Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 1 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/20, 1955, to 2/27, 1955, that I last saw the deceased alive on 2/27, 1955, and that death occurred at 7:20 P.M. from the causes and on the date stated above.

SIGNATURE George M. Simmons M.D. ADDRESS Cumberland, Md DATE SIGNED 2/27/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF March 2 1955

NAME OF CEMETERY OR CREMATORY Zion Evangelical Cemetery

LOCATION (City, town, or county) Frostburg, (State) Md

DATE REC'D BY LOCAL REGISTRAR March 2, 1955

REGISTRAR'S SIGNATURE Walter R. Krantz, M.D.

24. FUNERAL DIRECTOR ADDRESS William H. Kight, Cumberland, Md.

RECEIVED
MAR 4 1955
BUREAU V. L.

1173

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 01159

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Flintstone
LENGTH OF STAY (in this place) 17 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hurleys Branch Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural) Flintstone
STREET ADDRESS (If rural, give location) Hurleys Branch Road.

3. NAME OF DECEASED: (Type or Print) (First) Forman (Middle) Bruce (Last) Twigg

4. DATE OF DEATH (Month) Feb. (Day) 25 (Year) 19 55

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Single	Dec. 29-1882	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Farmer		Iron Mountain, Md.	U. S. A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Amon Twigg	Anna Catherine Quantz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no		sister) Dorothy Miller, ~~Flintstone~~ Cumberland R.F.D.2, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Coronary sclerosis	?
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐*

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☑
DATE SIGNED Feb. 26-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/27/55	Mt Herman Methodist	Near Cumberland Md

DEATH REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 28, 1955	Nora L. Benders	John J. Hafer	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01160

1174

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR X TOWN Luke
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cromwell Street.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke, X
STREET ADDRESS (If rural, give location) Cromwell Street,

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Charlotte (Last) Wagner.

4. DATE OF DEATH: (Month) (Day) (Year) February 11 1955.

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed.

8. DATE OF BIRTH: June 28, 1883.

9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cross, West Va.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Lewis Frederick Kight.

14. MOTHER'S MAIDEN NAME: Mary Murphy.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.
(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mrs. Helen Hutchinson.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	1 Hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Arterio-sclerosis and	5 Years
	(c) DUE TO Hypertension	5 Years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No X

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1949, to Feb 11, 1955, that I last saw the deceased alive on Feb 10, 1955, and that death occurred at 3:10 P m., from the causes and on the date stated above.

SIGNATURE Paul R Wilson (DEGREE OR TITLE) MD ADDRESS Piedmont, W. Va. DATE SIGNED 2-14-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF Feb. 14, 1955. NAME OF CEMETERY OR CREMATORY Philos Cemetery, LOCATION (City, town, or county) Westernport, Md. (State)

DATE REC'D BY LOCAL REG. 2-14-55

REGISTRAR'S SIGNATURE Mrs. Jean C. Kelly

24. FUNERAL DIRECTOR W. Harold Fuller ADDRESS Piedmont, W. Va.

1935
BUREAU V. S.

B Trewacke Jr

Kights

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1153 **CERTIFICATE OF DEATH**

01161

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
MARYLAND LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 932 Gay Steet

3. NAME OF DECEASED: (Type or Print) (First) Eastern (Middle) (Last) Welsh

4. DATE OF DEATH: (Month) 2 (Day) 7 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

8. DATE OF BIRTH. 10/1/77

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truckdriver

10B. KIND OF BUSINESS OR INDUSTRY: Liberty Hardware

11. BIRTHPLACE (State or foreign country): West Virginia Martinsburg

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Welch

14. MOTHER'S MAIDEN NAME: Adelaide (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: chart Sacred Heart Hospital Cumberland Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
490X IMMEDIATE CAUSE	(A) Chronic Myocarditis	2 yrs
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Arteriosclerosis	3 yrs
	DUE TO (C) Lobar pneumonia	3 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 4, 1955 to Feb 7, 1955, that I last saw the deceased alive on Feb 7, 1955, and that death occurred at 4 P. M, from the causes and on the date stated above.

SIGNATURE R. W. Trewacke Jr M.D. ADDRESS Cumberland, Md DATE SIGNED 2/9/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Feb 10 1955 | NAME OF CEMETERY OR CREMATORY St Peter & Paul Cemetery | LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REGISTRAR Feb. 10, 1955 | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md

Allegany Co. Health Dept. corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01162

1154 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS (If not in hospital or institution, give street address or location) 12 SACRED HEART HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 405 Beall Street

3. NAME OF DECEASED: (Type or Print) (First) HAZEL (Middle) D. (Last) WHITE

4. DATE OF DEATH: (Month) 2/4/55 (Day) (Year) 19

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 7/10/90
9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Private Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles F. Dayton
14. MOTHER'S MAIDEN NAME: Agnes Fathain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS. Chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
IMMEDIATE CAUSE 232X
(A) Bronchopneumonia DUE TO
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO
(C)
INTERVAL BETWEEN ONSET AND DEATH: 2 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary Artherosclerosis 5 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 19 55, to Feb. 4, 19 55, that I last saw the deceased alive on 2/1, 19 55, and that death occurred at 10:25 A.M., from the causes and on the date stated above.
SIGNATURE [illegible] M.D. ADDRESS Frene W. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 2-7-1955
NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 6, 1955
REGISTRAR'S SIGNATURE: Winter L. Frantz, M.D.
24. FUNERAL DIRECTOR: Charles L. George - Cumb. Md
ADDRESS

FEB
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01163

1155

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (In this place) 24 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 404 PRINCE GEORGE ST.

3. NAME OF DECEASED: (Type or Print) (First) ALPHONSUS (Middle) L. (Last) WILL

4. DATE OF DEATH: (Month) FEB. (Day) 21 (Year) 1955

5. SEX MALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED | 8. DATE OF BIRTH. FEB. 26, 1888 | 9. AGE Last birthday 66 yrs | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) Carpenter | 10B. KIND OF BUSINESS OR INDUSTRY CONTRACTOR-BLDG. | 11. BIRTHPLACE (State or foreign country) PA. New Baltimore | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN WILL

14. MOTHER'S MAIDEN NAME. SARAH WERNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No | (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Embolus — INTERVAL BETWEEN ONSET AND DEATH: About 24 hrs.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO Coronary Thrombosis

(C) Coronary Artery Dis.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertonia Chronic

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-28-, 1955 to 2-21-, 1955, that I last saw the deceased alive on 2-20-, 1955, and that death occurred at 1:40 A.M., from the causes and on the date stated above.

SIGNATURE W. F. Mullins M. D. ADDRESS Cumberland DATE SIGNED 2-21-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2-24-55 | NAME OF CEMETERY OR CREMATORY St Marys Cem. | LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 21, 1955 | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

[redacted] corporate limits OR. REITER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01164

1156 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 158 POLK ST.

3. NAME OF DECEASED. (Type or Print) (First) HELEN (Middle) LOUISE (Last) WINEBRENNER

4. DATE OF DEATH: (Month) FEB. (Day) 27 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) SINGLE

8. DATE OF BIRTH: DEC. 8, 1953

9. AGE last birthday: 1 yrs | IF UNDER 1 YEAR: Months 2 Days 19 | IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: LEONARD L. WINEBRENNER

14. MOTHER'S MAIDEN NAME: RUBY ROSLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS. Leonard Winebrenner, Cumberland Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

580+ IMMEDIATE CAUSE (A) Edema of brain with conus medullaris — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO acute hepatic necrosis — 1 month

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Intussusception, probable terminal — Four hrs.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 26, 1955, to Feb 27, 1955, that I last saw the deceased alive on Feb 27, 1955, and that death occurred at 7:25 AM, from the causes and on the date stated above.

SIGNATURE R. A. Reiter M.D. ADDRESS M.D. 112 Bedford St. DATE SIGNED Feb 27 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 3/2/55 — NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery — LOCATION (City, town, or county) (State) Cumberland Md

DATE REC'D BY LOCAL REGISTRAR March 1, 1955 — REGISTRAR'S SIGNATURE Wilbur R. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hofer — ADDRESS Cumberland Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01165

1175 CERTIFICATE OF DEATH Reg. Dist. No. 6

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Franklin
LENGTH OF STAY (in this place): 29 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: OO —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Franklin
STREET ADDRESS (If rural give location): —

3. NAME OF DECEASED: (First) Emma (Middle) Mary (Last) Wolfe
4. DATE OF DEATH: (Month) Feb (Day) 5 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed
8. DATE OF BIRTH: May 25, 1872
9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Moorefield, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: George Wolfe
14. MOTHER'S MAIDEN NAME: Francis Whetzel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Jesse Wolfe, Franklin, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
IMMEDIATE CAUSE: 422.2
(A) Chronic Myocarditis and Myocardial Degeneration not Specified as Rheumatic — INTERVAL BETWEEN ONSET AND DEATH: 2 Years
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Gastric Ulcer — 2 Months

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.): None
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 2, 1954, to Feb. 5, 1955, that I last saw the deceased alive on Feb 4, 1955, and that death occurred at 7:10 P M, from the causes and on the date stated above.
SIGNATURE Paul B Wilson M. D. ADDRESS Piedmont, W. Va. DATE SIGNED Feb. 8, 1955

23. BURIAL, CREMATION, REMOVAL* (SPECIFY): Burial
DATE THEREOF: 2-8-55
NAME OF CEMETERY OR CREMATORY: Bloomington Cem
LOCATION (City, town, or county) (State): Bloomington, Md.
DATE REC'D BY LOCAL REGISTRAR: 2-8-55
REGISTRAR'S SIGNATURE: Mrs Jean C. Kelly
24. FUNERAL DIRECTOR: E. S. Boge ADDRESS: Westernport, Md.

RECEIVED
1955
BUREAU V.

Within corporate limits 1157 01166

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND; CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland; LENGTH OF STAY (in this place) 4 1/2 hrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 313 Penna. Ave.

3. NAME OF DECEASED: (Type or Print) (First) Arzie (Middle) H. (Last) Yost

4. DATE OF DEATH (Month) Feb. (Day) 14 (Year) 19 55

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Aug. 12-1886

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Retired Hostler

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry.

11. BIRTHPLACE (State or foreign country): Fairmont, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Niel Yost

14. MOTHER'S MAIDEN NAME: Alice Mercer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-09-1195

17. INFORMANT & ADDRESS: Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Lobar pneumonia — Interval between Onset and Death: 5 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Adrenal hemorrhage (bilateral)

DUE TO

(c)

490 X 903 E

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture of left femur at surgical neck. 5 days

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION: next to his home

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. 6 1/5

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY vacant lot

21c. (City or town) Cumberland (County) Allegany (State) Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Feb. 11/55 P. M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Crossing vacant lot next to his home Blacked out, fell, fractured left femur.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ M. D.

DATE SIGNED Feb. 14-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Feb. 16, 1955

NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. Feb. 15, 1955

REGISTRAR'S SIGNATURE Walter K. Fauntz, M.D.

24. FUNERAL DIRECTOR James F. Scarfelli, " "

ADDRESS Scarfelli

VS. A15A - 5 - 53

RECEIVED
FEB 23 1955
BUREAU V. S.